BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
MICHELE CHAPMAN, M.D.	)	**Case No. 8002013000425**
Physician's and Surgeon's Certificate No. G56723	)	
Respondent	)	

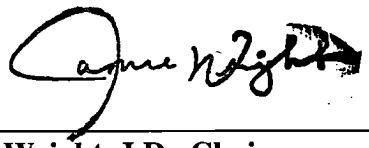
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 1, 2017.

IT IS SO ORDERED: August 4, 2017.

MEDICAL BOARD OF CALIFORNIA



Jamie Wright, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MICHELE CHAPMAN, M.D. Physician's and Surgeon's Certificate No. G 56723 Respondent.	Case No. 800-2013-000425 OAH No. 2016080761

A hearing convened in this matter before Marilyn A. Woollard, Administrative Law Judge, Office of Administrative Hearings, on April 4 and 5, 2017, in Sacramento, California.

Demond L. Philson, Deputy Attorney General, appeared on behalf of complainant, Kimberly Kirchmeyer, in her official capacity as Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

Respondent Michele Chapman, M.D., appeared on her own behalf.

Oral and documentary evidence was received, and the parties offered oral closing arguments at the conclusion of the hearing. The record was then closed and the matter was submitted for decision on April 5, 2017.

FACTUAL FINDINGS

1. On January 27, 1986, the Board issued Physician's and Surgeon's Certificate Number G 56723 to respondent. Respondent's certificate is renewed and current, with an expiration date of March 31, 2019. There is no prior disciplinary history.

For the past 33 years, respondent has practiced medicine primarily in rural emergency rooms. For two to three years before the events described in the Accusation, respondent worked shifts at the Glenn Medical Center (GMC) Emergency Department (ED) in Willows, California.

2. On July 14, 2016, complainant filed the Accusation, alleging there was cause to discipline respondent's license based on her care and treatment of patient M.G., who was

pregnant when she presented to GMC's ED in late September 2013, with pain in her right upper quadrant, a headache and an elevated blood pressure of 172/110.[1] Respondent was alleged to have ruled out labor, diagnosed M.G. with gastrointestinal (GI) disturbance, treated her for gastroesophageal reflux disease (GERD), and discharged her with a blood pressure of 160/94.

Two hours later, M.G. was transported by ambulance to Enloe Hospital (Enloe), where it was alleged the fetus had no cardiac activity and M.G. died "short after her arrival." Complainant asserted that respondent engaged in extreme departures from the standard of care under Business and Professions Code section 2234, subdivision (d) (gross negligence), by: (1) failing to recognize M.G.'s abdominal pain as Hemolysis Elevated Liver Enzymes Low Platelet Count (HELLP) Syndrome and treat her appropriately; (2) failing to adequately address and assess M.G.'s blood pressure; (3) failing to recognize and adequately stabilize M.G.'s preeclampsia; and (4) failing to consult an obstetrician (OB). These same failures were also alleged to constitute repeated negligent acts under Business and Professions Code section 2234, subdivision (c).

3. On July 20, 2016, respondent filed a Notice of Defense and requested a hearing on the Accusation. Her attorney at that time, Robert H. Zimmerman, Schuering Zimmerman & Doyle LLP, also filed a Notice of Special Defenses.

4. At the hearing, respondent appeared without counsel and elected to represent herself. Complainant called the following witnesses: Investigator Michel Veverka and expert Geeta Kumari Malik, M.D. Respondent testified on her own behalf. The testimony of these witnesses is paraphrased as relevant below. Respondent provided no evidence on special defenses.

M.G.'s Medical Records

5. M.G. was a 29-year-old Spanish-speaking farmworker in her 38th week of pregnancy who sought treatment at GMC's ED on September 29, 2013. She was admitted at 9:13 p.m. (2113 hours) for complaints of upper stomach/back pain with an 8/10 intensity. Two female friends accompanied M.G. and served as translators. Respondent was the only doctor on staff; she functioned as both the ED physician and as GMC's hospitalist. Registered Nurse (R.N.) David York was on duty in the emergency room and recorded M.G.'s vital signs, including her initial blood pressure reading of 172/110.

6. Respondent saw M.G. at 9:42 pm (2142 hours) and reviewed the nursing notes. M.G. had two previous deliveries without complications, and her due date was October 10, 2013. She denied nausea/vomiting, uterine pain, diarrhea or changes to stools. M.G. said that she had eaten "hot chilies and a meat sandwich about 5.5 hours ago. Then

[1] Patient M.G.'s true name, and that of her family members, is reflected in the Confidential Names List, which is subject to the April 4, 2017 Protective Order Sealing Confidential Records.

about 2-2.5 hours ago, she developed epigastric pain radiating up and toward her back that she said is getting worse. She denied any uterine cramping and says this is definitely not labor." Respondent noted that M.G. appeared well, but was in "moderate distress" and "very anxious." A Review of Symptoms identified bilateral headache that night. There were no noted vision problems.

On examination, M.G.'s abdomen was soft, non-distended, with tenderness in the right upper quadrant. She had a "gravid, non-tender, soft fundus." The fetal heart rate was 132. There was no entry under "Extremities: tender/swollen/edema." Under Procedures, respondent wrote: "GI cocktail [Maalox mixed with viscous Lidocaine] without Donnatal [an anti-spasmodic]. Patient feeling much better within 5 – 10 mins. Says the pain is getting better." M.G. was described as "improved" and a repeat blood pressure of 160/94 was noted "when pt was becoming calmer." In addition to the GI cocktail, M.G. was administered Tylenol 1,000 mg and Protonix 40 mg.

7. Respondent's recorded diagnosis was: "Epigastric pain of uncertain etiology; probable GERD; possible biliary colic; Term pregnancy (late 3rd trimester)." Disposition was to go home, in stable and improved condition. Patient was counseled about the plan and instructed to go to Enloe if she became worse. She was to contact the clinic for a sonogram during normal business hours. M.G. was provided two additional doses of the GI cocktail, with instructions to use one-to-two tablespoons every 2 hours as needed. The plan was for M.G. "to call her OB MD, and go to Enloe if worse." Respondent signed this medical record, checked as "complete," in the early morning hours on September 30, 2013.

8. Discharge Instructions: M.G. was discharged from GMC on September 29, 2013, at 10:45 p.m. (2245 hours). Respondent's Discharge Instructions provided: "Avoid spicy or fatty foods. Call #934-1800 in the morning and ask for the x-ray department in order to get a sonogram to look for gallstone. Use 1 – 2 tbsp. (15 – 30 cc) of the liquid every 2 hrs. as needed for dyspepsia. Also call your doctor if you are not better." Respondent signed the form, and provided a date of September 30, 2013, with a time notation of 2240. M.G. also signed the form, above a time notation "2045" [*sic*].[2] The Nurse Notes indicated that, at discharge, M.G.'s discomfort had reduced to 4/10 and her blood pressure was 160/94.

9. M.G.'s husband reported that, after she returned home, M.G. had at least three witnessed episodes of what he believed to be seizure, with loss of consciousness, general body convulsing, shaking and foaming at the mouth. He called 911. Paramedics arrived at 11:00 p.m. (2300 hours). M.G. was agitated and somewhat combative. Her blood pressure was 140/80; however, due to her agitation and pulling at the monitors, it was difficult to obtain her vital signs.

[2] Respondent noted several instances in the medical record in which R.N. York had incorrectly recorded time in military hours.

10. M.G. arrived at Enloe by ambulance on September 30, 2013, shortly after midnight at 0028 hours. On arrival, she again began to have seizures. Magnesium, preeclampsia labs, blood pressures and fetal monitors were ordered. No fetal heart beat was detected. M.G.'s blood pressure ranged from the high 160s-to-200 over 110-to-130. At 7:00 a.m., labor was induced and she delivered a still-born infant. M.G. was confused throughout the day. A neurological consultation was obtained. The family was ultimately advised that M.G. had no meaningful brain function and she was certified as brain dead on October 1, 2013.

Investigation

11. As reflected in the Butte County Certificate of Death, M.G. died at Enloe on October 1, 2013, at 2:11 p.m. (1411 hours). The immediate cause of death was Intracranial Hemorrhage, secondary to Maternal Eclampsia and Hemolysis Elevated Liver Enzymes Low Platelet Count Syndrome.

12. Following M.G.'s death, the California Department of Health and Human Services, Department of Public Health (CDPH), investigated and issued an Immediate Jeopardy Determination against GMC. CDPH later developed a Plan of Correction (POC) for GMC, which included mandatory staff education, OB rotations for emergency room physicians, and a requirement to change the emergency physician medical group from which GMC had previously obtained its providers. The POC reported that respondent was "unable to state the blood pressure range for patients with Preeclampsia." It reported that, when asked if a lab test to check for protein had been done, respondent "explained that there was no lab staff present in the facility" at the time of M.G.'s treatment, and that she would have used a urine dipstick had one been available in the ED. On October 17, 2013, CDPH referred a complaint about respondent to the Board, citing gross negligence and sub-standard care in her treatment, improper diagnosis and discharge of M.G.

13. At the time of M.G.'s treatment, GMC had policies and procedures in effect which provided that: "Pregnant women with consistently elevated blood pressure of 140/90 require OB Physician Consult . . . ." GMC conducted a Physician Review of M.G.'s treatment at the ED, and concluded that "this case was a failure to diagnosis [sic] severe preeclampsia which had fatal results for the patient and the baby. . . ." This led to GMC's updating its protocols for ED evaluation and treatment of OB patients, pursuant to the POC.

14. Respondent's Board Interview: Two years later, on October 19, 2015, Board Investigator Michele Veverka and Kevin Mitchell, M.D., conducted an interview with respondent. Respondent explained that M.G. reported she had horrible heartburn after eating chilies, and that she started to feel much better after respondent gave her the GI cocktail plus Tylenol and Protonix to decrease acid. Respondent noted that heartburn is "not rare" in pregnancy. M.G. possibly had GERD or, since the pain was on the right, she could have had gallstones. Her differential diagnosis was GERD, gallstones, or "just unknown etiology." M.G. was instructed to call in the morning to schedule a sonogram to see if she had gallstones.

Regarding M.G.'s hemodynamic stability, respondent stated that M.G.'s blood pressure did drop "not quite to normal, but something closer to normal" after she had the cocktail. She reiterated that M.G.'s blood pressure "was tending toward normal." M.G. was feeling "quite a bit better," was comfortable but tired, and said she wanted to go home to sleep. M.G. was discharged home with instructions to go directly to Enloe where she planned to deliver, or call her OB doctor, if she did not continue to improve or got any worse. Respondent had no reservations about discharging M.G. because she was confident M.G. understood the direction to go to Enloe if she was not improving or things got worse. Her friends seemed like a good support system.

When asked if elevated blood pressure was factored into her diagnosis, respondent stated that it would have raised more red flags if M.G. had not started feeling better. In addition, M.G.'s blood pressure was "trending down towards normal." At the time she treated M.G., respondent had been working shifts at GMC for several years. To her knowledge, GMC did not have an OB on-call for consultations or any protocols for treating pregnant patients. If respondent was going to transfer a pregnant patient to Enloe, she would have called and discussed the case with Enloe's OB.

Respondent noted that after M.G. was discharged, the ambulance called GMC and asked whether they should bring her back to GMC. Respondent explained that the instruction was still to take M.G. directly to Enloe, which was about 35 minutes away. Respondent then called Enloe to alert them M.G. was coming and to explain the prior treatment. Respondent was "a little bit" surprised to learn M.G. did not improve and needed to go to Enloe, because she had improved while in GMC's emergency room.

Several days later, respondent was informed by Dr. Carson, the head of her group, that M.G.'s baby had died and that M.G. was in critical condition. Respondent spoke to CDPH investigators by telephone. Following this investigation, all the doctors and nurses took a course in HELLP Syndrome. Respondent acknowledged that, at the time she treated M.G., she was not aware of HELLP Syndrome, because it was developed about a year after she finished that portion of her medical school training. She was aware of preeclampsia, its symptoms of hypertension, edema and fetal distress, and of the need to be "extremely careful." She reported that this case had not particularly changed her practice because she only saw an OB case maybe once a month and was currently treating a male inmate population. In hindsight, respondent wished she had been more aware of HELLP Syndrome and that she had the capacity to do a urine dip at GMC. She also would have called Enloe immediately.

15. On November 24, 2015, the case was referred for expert review to Geeta Malik, M.D. Dr. Malik reviewed the medical records from GMC and Enloe; the transcript of respondent's Board interview; respondent's Curriculum Vitae; CDPH's consumer complaint and plan of correction against GMC; and M.G.'s death certificate and the Coroner's report. In her December 27, 2015 report, Dr. Malik opined that respondent engaged in extreme departures from the standard of care as outlined in the Accusation.

Expert Opinion

16. Dr. Malik is a Family Physician with Prima Medical Group in Sonoma. She obtained her medical degree from Creighton University School of Medicine in Omaha, Nebraska in 1993, and she has been licensed in California since 1994. From 1993 through 1996, Dr. Malik completed a Family Practice Residency Program at Merrithew Memorial in Contra Costa County, California. She then completed a two-year Family Practice/OB Fellowship at the University of Tennessee in Forrest City, Arizona and Memphis, Tennessee. Dr. Malik has been certified by the American Board of Family Medicine since 1996. Before relocating to California, Dr. Malik was a Clinical Assistant Professor at the Department of Family and Community Medicine at Baylor College of Medicine in Texas, where she also served as a Physician Consultant and Patient Monitor for the Texas State Board of Medical Examiners. Dr. Malik has worked as a physician consultant and an expert reviewer for the Board since 2011.

17. In reviewing M.G.'s medical records, Dr. Malik noted that no labs were done on M.G. at GMC, including a urine dip for protein. In her physical examination of M.G., respondent did not document M.G.'s reflexes, whether or not there was any clonus, or whether edema was present. A review of M.G.'s medical record showed that her blood pressure had previously been in the range of "110's/70-80's." Based on her records review, Dr. Malik identified four areas in which respondent had departed from the standard of care in her treatment of M.G.

18. Failure to adequately care for a pregnant patient near term with abdominal pain: Dr. Malik reported that it is the standard of care to evaluate a patient who presents for emergency. Abdominal pain in a near-term pregnant patient "raises specific concerns, including the clinical entities of normal labor, preeclampsia, uterine rupture, HELLP and hepatic capsular rupture (both complications of severe preeclampsia) and placental abruption." Due to the severity and possibility of rapid deterioration of both the fetus and the mother with these conditions, they "must be ruled out with laboratory evaluation and/or a period of observation. This must be done in consultation with OB or those who care for pregnant patients (i.e., Family Physicians who practice obstetrics)."

Based on M.G.'s clinical presentation of right upper quadrant abdominal pain, headache and an elevated blood pressure, preeclampsia "needed to be ruled out. Preeclampsia labs (CBC, LFTS, uric acid) should have been drawn." In Dr. Malik's opinion, these labs would have assisted in evaluating for HELLP Syndrome, for hepatic rupture, and for respondent's alternate diagnosis that M.G. may have had gallstones. Dr. Malik reviewed M.G.'s lab values later obtained at Enloe. In her opinion, had M.G.'s urine be tested at GMC, respondent "would have likely found proteinuria and elevated liver enzymes, and perhaps the thrombocytopenia would have been present by them." Instead of doing so, respondent ruled out labor and treated M.G. for GERD, more than five hours after she had consumed the spicy meal. In Dr. Malik's opinion:

> The more serious entity of preeclampsia needed to be excluded before assuming M.G.'s complaints were benign and discharging M.G. with a BP of 160/94. GERD and cholelithlasis did not fit the entire clinical picture (timing of meal, explanation of the headaches, severity of the BP elevation). [Respondent] did not alert M.G.'s OB provider of her ED evaluation. The fetus was not monitored except by a one-time fetal heart tone measurement.

Dr. Malik explained that preeclampsia at term should be treated "by stabilizing the mother, loading with magnesium sulfate to reduce seizure risk, placing fetal monitors and arranging for delivery." This would have required consultation and M.G.'s transfer to Enloe.

Based on her "failure to recognize M.G.'s abdominal pain as the serious HELLP Syndrome (a sub-syndrome of preeclampsia) and treat her appropriately," respondent engaged in an extreme departure from the standard of care in her treatment of M.G.

19. Failure to evaluate and treat elevated blood pressure in a term pregnant patient: Dr. Malik reported that it is the standard of care to evaluate the blood pressure of every pregnant patient when they present for emergency care, and that every pregnant patient with elevated blood pressure should be evaluated for preeclampsia. The elevated blood pressure should not be attributed to pain or distress, and other diagnoses can be considered but only after preeclampsia has been ruled out. This is because failure to recognize preeclampsia "can lead to the more serious condition eclampsia and/or real clinical consequences." The pregnant patient with new-onset blood pressure elevation should not be discharged. Elevated blood pressure at term is typically managed by maternal and fetal monitoring and arranging for delivery. Dr. Malik explained that:

> Preeclampsia is a syndrome and, as such, has no specific test to diagnose it. HELLP is when a preeclamptic patient has hemolysis, elevated liver enzymes and low platelets. Clinicians must maintain a high index of suspicion and consider the diagnosis in pregnant patients who present with risk factors such as elevated blood pressure, headache and edema. Exam should document the presence or absence of abdominal pain, edema, papilledema and brisk reflexes and/or clonus. Patients may not have all these signs and symptoms but may still have preeclampsia. Testing should include blood work and urine. Extended monitoring of the fetus and IV magnesium should be started. OB consultation should be obtained, along with arrangements for delivery. Delivery lessens, but does not eliminate, the risk of eclampsia.

In Dr. Malik's opinion, M.G. met the criteria for preeclampsia, and this was confirmed by testing at Enloe that showed she had HELLP. Respondent should not have

attributed M.G.'s condition to GI distress and she should have ordered preeclampsia labs "despite the inconvenience." Respondent should have ordered magnesium and arranged for M.G.'s transfer to Enloe. While M.G.'s blood pressure had lowered to 160/94, this was probably a result of bed rest while in GMC's ED. M.G.'s "improved" blood pressure was still in the preeclamptic range and she was still in danger. Respondent should not have discharged M.G. "without, at a minimum, consulting MG's OB or the one on call at Enloe." In Dr. Malik's opinion, respondent engaged in an extreme departure from the standard of care by failing to adequately address and assess M.G.'s elevated blood pressure.

20. Failure to recognize preeclampsia: As discussed above, preeclampsia should be ruled out in a pregnant patient at term with elevated blood pressure. Dr. Malik reported that it is the standard of care for an emergency department provider to be aware of the possible complications of pregnancy and their presentations. While such provider does not have to provide comprehensive care to the pregnant patient, "in situations where a pregnant patient needs more extensive care or the diagnosis is in question, consultation and or transfer should be arranged."

In this case, M.G. presented with abdominal pain, headache and elevated blood pressure at term. "This is preeclampsia." Respondent did not check M.G.'s reflexes, document that there was no edema and she "did not order labs and a urine dip to rule out preeclampsia. It does not appear that she even considered the diagnosis preeclampsia." In Dr. Malik's opinion, respondent's failure to recognize and adequately stabilize a patient with preeclampsia was an extreme departure from the standard of care.

21. Failure to consult OB: Dr. Malik reported that it is the standard of care for emergency department providers to consult "when faced with a case that is challenging or complicated or needs further evaluation or care." "Liberal consultation and arrangement for close follow up" is required, especially where emergency department providers do not regularly provide obstetric care.

In this case, M.G.'s blood pressure was still elevated at discharge. Although respondent ordered a gallbladder ultrasound for the following morning, M.G. was Spanish speaking. Rather than discharging her, at the very least, respondent should have contacted M.G.'s OB to have them follow up on the ultrasound and blood pressure. "Ideally, what she should have done was consult the OB due to the elevated BP; they would have likely told her to order labs and/or transfer her care to them." In Dr. Malik's opinion, respondent's failure to consult an OB in her care of M.G. was an extreme departure from the standard of care.

22. Dr. Malik's testimony was largely consistent with her report, and she clarified or corrected several items in her report. She noted, for example, that the medical records did not document that M.G. had blurred vision as reported in the CDPH complaint; and that M.G.'s initial blood pressure was actual 172/101, not 174/110, as reflected in her report. That M.G. did not have documented blurred vision did not change Dr. Malik's opinions, because headaches, elevated blood pressure and right upper quadrant pain alone support a diagnosis of preeclampsia. Dr. Malik ultimately agreed with respondent that M.G. did not

die "shortly" after arrival at Enloe, but had lived for approximately 39 hours after her discharge from GMC. In response to respondent's questions about potential deviations from the standard of care by Enloe physicians who may have delayed discovery of M.G.'s intracranial hemorrhage, Dr. Malik advised that her sole obligation was to review respondent's care and treatment of M.G.

Dr. Malik emphasized that preeclampsia should have been at the top of respondent's differential diagnoses. In her experience, doctors who do not practice obstetrics typically err on the side of consulting, which is an easy action to take. Such consultation is crucial before "chalking symptoms up to a benign condition." Had consultation occurred, M.G. would likely have been transferred immediately to Enloe. Dr. Malik reiterated her opinion that respondent engaged in four extreme departures from the standard of care as detailed in her report. She provided no testimony on whether respondent had engaged in any repeated negligent acts in her care and treatment of M.G.

Respondent's Evidence

23. Testimony: Respondent received her medical degree from the University of California (U.C.), San Francisco in 1984, one year after she earned a Master of Public Health from U.C., Berkeley. From 1984 through 1987, she completed a Family Practice Internship at San Francisco General Hospital, followed by a Family Practice Residency at Merrithew Memorial Hospital in Martinez. Respondent received her California license in 1986, and was certified by the American Board of Family Medicine in 1987, with her most recent recertification in August 2008. Since 1987, respondent has practiced as a staff physician in the emergency departments of various rural hospitals, typically as an independent contractor, through the Valley Emergency Physicians.[3] The bulk of respondent's practice has been in rural hospitals, a unique setting in which she was typically the only physician on staff and acted as both the emergency provider and hospitalist. Her most recent position was at the Salinas Medical Center, treating a male inmate population through the California Department of Rehabilitation and Corrections.

24. Respondent agreed with Dr. Malik's expert report in many respects. For example, respondent agreed that she failed to adequately care for a pregnant patient near term with abdominal pain and that this was a departure from the standard of care. As discussed below, respondent testified that she did consider preeclampsia. However, she agreed that she failed to recognize and adequately stabilize a patient with preeclampsia before discharge and that this was a departure from the standard of care. She agreed that she departed from the standard of care by "her failure to consult OB in her care of M.G." Respondent clarified that her first call would not have been to M.G.'s OB, but to the OB on-call at Enloe who would most immediately accept care.

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[3] These include Oakland Hospital (1987-1987), Yolo General Hospital (1988 -1991), John C. Fremont Hospital (1991-1998; 2007 to present); Modoc Medical Center (1995-1998); Loyalton District Hospital (1996-2002); Corcoran District Hospital (2001-2008); and the Glenn Medical Center (2011 to 2013).

25. Respondent disagreed that she failed to evaluate and treat elevated blood pressure in a term pregnant patient and that she knowingly discharged M.G. with a high blood pressure. However, she acknowledged that her medical chart as written supports this conclusion. Respondent provided a detailed explanation of what occurred when M.G. was treated at GMC on September 29, 2013, which she did not disclose during her Board interview. As the only doctor in rural clinics, respondent felt a heavy mantle of responsibility for the staff with whom she worked. She also developed certain "short-cut" practices to facilitate handling her patient load. One of these practices was to write prescriptions, medical chart notes and discharge instructions shortly after seeing a patient, based upon her tentative prognosis and treatment plan. Respondent wrote the prescriptions and signed the chart notes and discharge summaries. She then placed these documents on the desk in her office. She frequently shredded these initial documents when they were no longer applicable; however, at other times, she placed them into the rack outside her office where nurses retrieved discharge instructions and orders for processing.

Respondent believed M.G.'s initial blood pressure was too high due to pain. After their initial encounter, respondent went into the examining room and saw M.G. on three to five occasions and noted her improvement following the GI cocktail. She was aware that M.G.'s second blood pressure reading was 160/94. While respondent believed M.G.'s decreased blood pressure and lessened pain confirmed her diagnosis, she still believed M.G.'s blood pressure was too high. Respondent explained that her personal standard for blood pressure in pregnant women is more conservative than the national standard. She has treated approximately 9,000 pregnant women for various conditions in her career. Typical blood pressures are 110/60, but she has seen it as high as 120/70. Respondent's plan was to have R.N. York take a third blood pressure reading on M.G. If that anticipated reading was still high, respondent had no intention of discharging M.G. due to possible preeclampsia.

At the time, GMC's ED did not have the capacity to do urine dips, fetal monitoring or sonograms.[4] Respondent did not order labs for M.G., because there was no one in the hospital to take them and it would have taken over an hour to call the lab person, have that person return to GMC, perform the test and obtain the results. If M.G. had persistent high blood pressure on the third reading, respondent intended to have her transported to Enloe, which had lab capability. At the same time, respondent had already instructed R.N. York to mix up some extra GI cocktail for M.G. to take home with her, in case she was discharged. Respondent was then called away for approximately 10 minutes, possibly to the hospital. When she returned to ask for a third blood pressure reading, R.N. York advised respondent that he had discharged M.G. with the extra GI cocktail, because she felt better and wanted to go home. He had taken the papers off respondent's desk and had M.G. sign the discharge document. R.N. York apologized.

Respondent testified that she has seen over 100,000 patients in her career and had never before had one accidentally discharged. She had to make a decision about what to do.

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[4] Respondent testified that she had complained about the lack of urine dip sticks for several years at GMC "to no avail."

Respondent concluded it was a "well-meaning mistake" by R.N. York, who she believed to be a good and competent nurse, and she chose to protect him. Respondent educated R.N. York about preeclampsia and the risks it creates. She did not call M.G.; however, within a short time, the ambulance service called to find out if M.G. should be transported back to GMC or Enloe. Respondent then felt reassured that M.G. would receive appropriate care. Respondent called Enloe to brief its staff about M.G.'s treatment at GMC.

In the early morning hours of September 30, 2013, believing the risk to M.G. was over, respondent had to decide what to do about her chart note for M.G. This was a crucial decision point because another GMC nurse had recently been fired. Respondent believed that R.N. York would be fired if she wrote anything about preeclampsia in the chart. After an internal debate, respondent wrote the diagnoses on the chart, without mentioning preeclampsia.

In her testimony, respondent lamented the "extraordinary devastation of a simple mistake." She later learned that M.G. had seizures at home. Had she known this, respondent would have instructed the ambulance to bring M.G. back to GMC, the closer facility, where magnesium could have been administered. Within several days, respondent and R.N. York learned that the infant died. It was not until August 2015, when she was named in a lawsuit by M.G.'s family, that respondent learned M.G. had also died. Respondent had no contact with R.N. York from December 2013 until shortly before this hearing. She then learned he had been fired from GMC shortly after this episode, had never worked as a nurse again and that he had dementia. The deaths of M.G. and her infant have weighed heavily on respondent.[5] Respondent only recently learned from the medical records that M.G. did not die until 39 hours after she was admitted to Enloe, rather than "shortly after" admission as alleged in the Accusation. She urged the Board to also investigate why the Enloe medical staff took so long to determine that M.G. had intracranial hemorrhaging.

Respondent did not disclose these facts during her Board interview or at any time prior to her hearing testimony. She explained this was based on her training through Valley Emergency Physicians that she should never discuss a case except with her supervisor, where litigation is likely pending. Also, at that time, she believed R.N. York was still working as a nurse. Now, because her attorneys in the pending civil suit told her that "her ship has sailed" as far as her medical license is concerned, respondent wanted to set the record straight.

26. Respondent is now 69 years old and has recently retired. Although she had to disclose her retirement on her renewal application, respondent's Physician's and Surgeon's license is renewed and active through March 19, 2019. Respondent hopes to be able to use her Master of Public Health to do some non-clinical work in the future. She believes this would be difficult to do if her medical license is revoked. She characterized her 33 years of practice as a physician as an honor and a privilege. She has never taken her responsibility for patients' care lightly.

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[5] Respondent testified that R.N. York was similarly affected with a huge burden of guilt.

27. *Recommendations and Certificates*: Respondent provided a one-page ungraded Post-Test for "Common Obstetrical Emergencies Encountered in the ED," which she completed on November 6, 2013.

She offered copies of recommendations of her skills as a physician provided to Valley Emergency Physicians in August 1991, from the Chief of Staff of Yolo General Hospital (name indecipherable), who described her as an "excellent primary care and E.R. Physician," and the Credentials Chair of Merrithew Memorial Hospital (name indecipherable), who characterized her as "an industrious, competent, compassionate, ethical physician who has demonstrated good judgment and initiative . . . only superlatives."

In 2010, GMC sought recommendations related to respondent's application for staff privileges from Marcus Shouse, M.D., and Myron Denny, M.D. Dr. Shouse described respondent as an "excellent mature physician." Dr. Denny wrote:

> Dr. Chapman is a highly competent, skilled, dedicated, resourceful, conscientious, engaged, caring doctor, who works well in harmony with patients, other medical professionals and administration. I recommend her unequivocally.

On March 5, 2013, Dr. Denny renewed his recommendation to GMC in response to respondent's application for reappointment and staff privileges. In particular, Dr. Denny noted respondent's "laudable clinical skills and impeccable ethics and caring attitude."

Discussion

28. Dr. Malik was the sole medical expert witness. Her testimony was thorough and persuasive. Respondent accepted responsibility and substantially concurred with Dr. Malik's assessment on three of the four alleged extreme departures from the standard of care. As respondent acknowledged, her testimony that she did not knowingly discharge M.G. with high blood pressure and was actively considering whether M.G. had preeclampsia is flatly contradicted by her own medical record. This record outlined her diagnosis and treatment plan with no mention of any consideration for M.G.'s elevated blood pressure or possible preeclampsia. In her testimony, respondent appeared credible; however, she also presented as responsive and candid in her statements to investigators during the Board interview. Ultimately, respondent is bound by the diagnosis and plan she set out for M.G. in her treatment notes, which reflect no consideration was given to M.G.'s two elevated blood pressures despite her near term pregnancy and that she was discharged to home without prior consultation with an obstetrician. Respondent's failure to check for edema or clonus during her examination also reinforces the conclusion that, in her differential diagnosis, respondent did not consider the most serious possible medical condition confronting M.G.

When all the evidence is considered, complainant established by clear and convincing evidence that respondent engaged in the four extreme departures from the standard of care outlined above. The Board's Manual of Model Disciplinary Orders and Disciplinary

Guidelines (12th Ed., 2016) have been considered. These Guidelines provide that, where not inconsistent with public protection, "disciplinary actions shall be calculated to aid in the rehabilitation of licensees." Given respondent's previously unblemished 33 years of licensure, the public can be protected by revoking her license, staying the revocation, and placing her on probation subject to the terms and conditions outlined below.

LEGAL CONCLUSIONS

1. *Purpose of Physician Discipline*: The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Disciplinary proceedings protect the public from incompetent practitioners by eliminating those individuals from the roster of state-licensed professionals. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

2. *Burden and Standard of Proof*: To revoke or suspend respondent's medical license, the complainant must establish the allegations and violations alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

3. Business and Professions Code section 2234 provides that the Board "shall take action against any licensee who is charged with unprofessional conduct." Such unprofessional conduct includes, but is not limited to, gross negligence, and repeated negligent acts.

4. *Gross Negligence*: Pursuant to Business and Professions Code section 2234, subdivision (b), the Board may discipline a licensee's medical license for gross negligence. Gross negligence is defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941; *Franz v. Board of Medical Quality Assurance* (1982) 31 Cal.3d 124, 138; *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196.)

As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Factual Findings 16 through 24 and 28, complainant established by clear and convincing evidence that respondent was grossly negligent in her care and treatment of M.G. by her failure: (1) to adequately care for a pregnant patient near term with abdominal pain; (2) to evaluate and treat elevated blood pressure in a term pregnant patient: (3) to recognize preeclampsia; and (4) to consult an obstetrician.

5. *Repeated Negligent Acts*: Pursuant to Business and Professions Code section 2234, subdivision (c), the Board may discipline a licensee's medical license for "repeated negligent acts." As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Factual Findings 22 and 28, there was no expert witness testimony that respondent's treatment of M.G. involved repeated negligent acts. Legal cause was not established to discipline respondent's license based on the allegations of repeated negligent acts.

6. Following a an administrative hearing, a licensee may be disciplined by having her license revoked, staying that revocation and placing her on probation, subject to terms and conditions that include paying the costs of probation monitoring. (Bus. & Prof. Code, § 2227, subd. (a)(1) and (3).) As set forth in the Factual Findings and Legal Conclusions as a whole, respondent has had no previous discipline in her lengthy medical career. The public can be protected by placing respondent on probation, subject to the conditions outlined below.

ORDER

Physician's and Surgeon's Certificate Number G 56723 issued to respondent Michele Chapman, M.D., is hereby REVOKED pursuant to Legal Conclusion 4; however, revocation is STAYED, and respondent is placed on three (3) years of probation, with the following terms and conditions:

1. **Education Course (Condition 14):** Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. **Medical Record Keeping Course (Condition 15):** Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at

respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **Professionalism Program (Ethics Course) (Condition 16):** Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. **Clinical Competence Assessment Program (Condition 18):** Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical

Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after respondent has successfully completed the clinical competence assessment program, respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

5. **Notification:** Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to

respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. **Supervision of Physician Assistants and Advanced Practice Nurses:** During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. **Obey All Laws:** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. **Quarterly Declarations:** Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. **General Probation Requirements:**

Compliance with Probation Unit:
Respondent shall comply with the Board's probation unit.

Address Changes:
Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice:
Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal:
Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California:
Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the dates of departure and return.

10. **Interview with the Board or its Designee:** Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. **Non-practice While on Probation:** Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

12. **Completion of Probation:** Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

13. **Violation of Probation**: Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. **License Surrender:** Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. **Probation Monitoring Costs:** Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: May 5, 2017

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MARILYN A. WOOLLARD
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHELE CHAPMAN, M.D.** **P.O. Box 5008 PMB 250** **Mariposa, CA 95338-5008** **Physician's and Surgeon's Certificate No. G 56723,** Respondent.	Case No. 800-2013-000425 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about January 27, 1986, the Medical Board issued Physician's and Surgeon's Certificate Number G 56723 to MICHELE CHAPMAN, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2017, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

6. Respondent MICHELE CHAPMAN, M.D. is subject to disciplinary action under section 2234, subdivision (d), in that she was grossly negligent in the care and treatment of a patient. The circumstances are as follows:

7. It is the standard of care to evaluate a patient who presents for emergency care. Abdominal pain in a near-term pregnant patient raises specific concerns, including the clinical entities of normal labor, preeclampsia, uterine rupture, severe complications of preeclampsia and placental rupture. The severity and possibility of rapid deterioration of both fetus and mother with many of the above conditions requires them to be ruled out with laboratory evaluation and/or a period of observation. This should be done in consultation with an OB/GYN or those who care for pregnant patients (i.e., family physicians who practice obstetrics).

8. On or about September 30, 2013, Patient M.G. presented to emergency care at Glenn Medical Center (GMC) for abdominal pain at 38 weeks. She suffered from pain in the right upper quadrant, a headache, and an elevated blood pressure (BP) of 174/110. Preeclampsia laboratory tests were not done to rule out preeclampsia. Instead, Respondent ruled out labor and proceeded to treat the patient for gastroesophageal reflux disease (GERD). The fetus was not monitored except for a one-time fetal heart measurement. She discharged the patient with a BP of 160/94. The diagnosis was "GI disturbance." Two hours later, the patient was transported to Enloe Hospital. The fetus had no cardiac activity. Patient M.G. died shortly after her arrival. The listed cause of death was intracranial hemorrhage secondary to eclampsia due to HELLP. HELLP is when a preeclamptic patient has hemolysis, elevated liver enzymes and low platelets.

9. The protocols in place at GMC when M.G. presented to the ER required OB consultation for pregnant patients with an elevated BP. Respondent did not alert the patient's OB/GYN of her ED evaluation.

10. The fetus was not monitored except by a one-time fetal heart tone measurement.

11. Respondent engaged in an extreme departure from the standard of care in her care and treatment of patient M.G. in that she failed to recognize the patient's abdominal pain as the serious HELLP syndrome and treat her appropriately.

12. It is the standard of care to evaluate the BP of every pregnant patient upon presentation for emergency care. Any pregnant patient with elevated blood pressure should be evaluated for preeclampsia. Other diagnoses can be considered after this entity has been ruled out, as failure to recognize this entity can lead to the more serious condition eclampsia and/or real clinical consequences. Even the more benign condition of pregnancy, pregnancy induced hypertension (PIH), has complications such as intrauterine growth restriction (IUGR), placental abruptions and advancement to preeclampsia. For this reason, elevated BP at term is usually managed by maternal and fetal monitoring and arranging for delivery. The patient should not be discharged with new-onset BP elevation and their elevated BP should not be attributed to pain or distress until preeclampsia is ruled out.

Preeclampsia is a syndrome and, as such, has no specific test to diagnose it. Clinicians must maintain a high index of suspicion and consider the diagnosis in pregnant patients who present with risk factors such as elevated blood pressure, headache and edema. The presence or absence of abdominal pain, papilledema, and brisk reflexes and/or clonus should be documented. Patients may not have all of these signs and symptoms yet still have preeclampsia. Testing should include blood work and urine. Extended monitoring of the fetus and IV magnesium should be started. An OB/GYN consultation should be obtained, along with arrangements for delivery. Delivery lessens but does not eliminate, the risk of eclampsia.

13. Patient M.G. met the criteria for preeclampsia. She did not carry a diagnosis of pregnancy induced hypertension. Respondent should have ordered preeclampsia laboratory tests, administered magnesium, and transferred the patient to Enloe Hospital. Although the patient's BP had dropped to 160/94, she was still in danger because her BP at 160/94 was still in the preeclamptic range. Respondent should not have discharged the patient without, at a minimum consulting the patient's OB/GYN or the one on call at Enloe Hospital.

14. Respondent engaged in an extreme departure from the standard of care in her care and treatment of patient M.G. in that she failed to adequately address and assess the pregnant patient's BP.

15. It is the standard of care for an ED provider to be aware of the possible complications of pregnancy and their presentations. Comprehensive care of the pregnant patient does not have to be provided, but in situations where a pregnant patient needs more extensive care or the diagnosis is in question, consultation and/or transfer should be arranged. Preeclampsia should be ruled out before any other diagnosis is considered for a patient at term presenting with an elevated BP.

16. It is the standard of care to consult with the ED when faced with a case that is challenging or complicated or needs further evaluation or care. The emergency care of pregnant patients, especially from those providers who do not regularly provide obstetric care, should include liberal consultation and arrangement for close follow up.

17. Patient M.G. presented to Respondent with the symptoms of preeclampsia: abdominal pain, headache, and elevated BP at term. Respondent did not check the patient's reflexes or document on examination that there was no edema. Respondent did not order laboratory tests and a urine dip to rule out preeclampsia.

18. Respondent engaged in an extreme departure from the standard of care in her care and treatment of patient M.G. in that she failed to recognize and adequately stabilize the patient with preeclampsia.

19. Respondent engaged in an extreme departure from the standard of care in her care and treatment of patient M.G. in that she failed to consult an OB/GYN.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

20. Respondent MICHELE CHAPMAN, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), for her repeated acts of negligence in the care and treatment of a patient. The circumstances are as follows:

21. Paragraphs 7 through 17 are incorporated herein as if fully set forth.

22. Respondent committed repeated negligent acts in her care and treatment of Patient M.G. which included, but were not limited to, the following:

a. She failed to perform to recognize the patient's abdominal pain as the serious HELLP syndrome and treat her appropriately;

b. She failed to adequately address and assess the pregnant patient's BP;

c. She failed to recognize and adequately stabilize the patient with preeclampsia; and

d. She failed to consult an OB/GYN.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 56723, issued to MICHELE CHAPMAN, M.D.;

2. Revoking, suspending or denying approval of MICHELE CHAPMAN, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering MICHELE CHAPMAN, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: July 14, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SA2016300167